Child Abuse and Neglect Fatalities In Hampton Roads

(July 1, 2014 to June 30, 2015)

FY 2015 One-Year Report
Preliminary

Eastern Region
Child Fatality Review Team

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MISSION STATEMENT

We recognize that the responsibility for responding to and prevention of child fatalities lies with the community, not with any single agency or entity. We recognize that promoting more accurate identification and reporting of childhood fatalities will result in the development of prevention strategies for all childhood injuries in Virginia. Finally, we recognize that the implementation of fatality review panels will lead to improved coordination of services for children and families at the local level.

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FOREWORD

This Report reflects the work the Eastern Region Child Fatality Review Team has done for the past twenty years.

The report primarily reflects the cases reviewed by the team between July 1, 2014 and June 30, 2015(FY 15). The Appendices reflect the 20 years of case review done by the Team.

The Executive Summary outlines the most recent findings and recommendations.

The body of the document discusses the history of the team and describes the larger areas of concern and outlines team on-going prevention recommendations and strategies to address these targeted concerns.

There are detailed yearly charts in the back of the report for each year the team has been reviewing cases. In recent years, realizing the importance of collected information is in the prevention planning process, the team has begun to increase the amount of data collected. Beginning with FY 11 cases, the data from the Team's review has been entered into the National Child Death Review Case Data System. For more information on this go to- http://www.childdeathreview.org/reporting.htm

The purpose of this report is to increase awareness not only for professionals but the public at large on how we can make the world a safer place for all of the children of our community.

EXECUTIVE SUMMARY – FY 2015 REPORT

Significant Findings of the Eastern Region Child Fatality Review Team - *(July 1, 2014 - June 30, 2015)*

At the time this report is being published the Eastern Region has 13 founded child fatality cases. Statewide a total of 6 cases are pending and 3 state cases are on administrative appeal. The statistics reflected in this report are not final as these cases cannot be officially counted until their status is resolved. (March 28, 2016)

- **There were 13 child deaths in Hampton Roads (the Virginia Department of Social Services Eastern Region)** found to be caused by the abuse or neglect of a caretaker in FY 2015.

- **Approximately 25% (13) of the child fatalities in Virginia (52) during FY15 due to abuse or neglect took place in the Eastern Region.** *(According to the U.S. Census taken in 2010, 23% of the state's children live in this region.)*

- **The overall number of fatalities due to abuse or neglect in the region have remained high in recent years.** 10 deaths occurred in FY 2011; 16 in FY 2012; 16 in FY 2013; 17 FY 2014 and 13 in FY 2015.

- **Three (25%) of the 13 children who died were infants who had not reached their first birthday; six additional victims were age two or under. Two-thirds of the children who died were under the age of three.**

- **Five out of 13 (38%) of the children or families (where information was available) had previous or current contact with social services. Two families had a screened out case. At least five of the abusers had previous social service assessments or findings.**

- **A significant number of children are dying in the care of their parents –** approximately 80% of the children who died were in the care of their biological (or step) mother, father or both. One child died under the care of the mother's paramour, one was being cared for by a grandmother and one died in an unlicensed child care.

- **Five of the founded and two of the unfounded deaths were as a result of drowning.** Only one of the FY14 deaths was as a result of drowning.

- **Thirty-three of the cases the Team reviewed were unfounded,** out of a total of 46 cases the Eastern Region DSS agencies investigated in FY15. In FY 15, statewide there were 131 total cases investigated. Thirty-five percent of the state's investigations were in the Eastern Region which is only one of five state social service regions. (Last year approximately 37% of the state's fatality investigations occurred in the Eastern Region and in the previous year almost half of the state investigations were done in the region.)

- **Twenty-one of the unfounded deaths were associated with unsafe sleeping environments** such as co-sleeping with an adult (14), soft bedding, being laid to sleep on their stomach, and/or sleeping in an adult bed, couch, car seat or other surface not intended for infant sleeping. In FY 14, 15; in FY 13, 18; and in FY 12, 25 of the unfounded Eastern Region fatalities occurred in unsafe sleep environments. Statewide, 57 of the 131 (44%) fatalities were sleep-related; locally the percentage was 46%. Twelve of the 21 sleep related fatalities occurred in families with current or previous social service involvement.

- **Many child deaths are preventable. There should be ongoing efforts in Virginia and in Hampton Roads focused on reducing the number of child fatalities in the region.**

***** The region served by the Team is large and diverse. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, and Franklin. It also includes the counties of Accomack, Isle of Wight, Surry, Southampton, Northampton, James City, and York-Poquoson. The regional lines are moved sporadically by the state and during the fifteen-year review period the region has grown to include Brunswick, Dinwiddie, Gloucester, Greenville, Mathews, Prince George and Sussex Counties. (Total number of agencies is 23.)

RECOMMENDATIONS
Eastern Regional Child Fatality Review Team FY 2015

The Hampton Roads / Eastern Regional Child Fatality Review Team will have reviewed 46 cases from FY15 child deaths investigated by regional child protective services. The Team reviewed 47 cases in FY14. The team as part of the case reviews made recommendations to agencies and the community addressing specific gaps and deficiencies whose correction enable better investigations and prevention. Based on the FY15 reviews, the Team makes the following recommendations. (**Recommendations in bold are new based on the FY15 reviews.** The others are recommendations from previous years (but based on issues seen in the current fiscal year's cases) that still need attention.

EDUCATION

Child Abuse/Neglect:

- Work with the Supreme Court of Virginia to insure that judges receive on-going training on neglect, chronic neglect, failure to thrive, child sexual abuse and early childhood brain development. Also needed is training on the use of protective orders to address parental compliance with and participation in services. Judges should also be educated about options available to them to protect vulnerable children remaining in home(s) when parents deny social service and in-home service providers access to the home during an assessment, investigation, or when social services has on-going services in place or when Child Protective Services (CPS) has entered into a safety plan with the caretaker/s.
- Conduct and encourage others to conduct on-going education on the recognition of child abuse, child neglect, medical neglect and failure to thrive for the professional community with special focus on health care providers that serve children and families and all school personnel, but especially staff working with special education students.
- **Encourage probation officers to be more vigilant and proactive around probationers with pregnancy and issues that might impact their pregnancy like substance abuse, mental health, domestic violence or homelessness.**
- Encourage and/or sponsor regional cross-agency trainings on child abuse and neglect identification, prosecution and prevention. Find ways to make this training available to the more rural and underserved areas of the region.
- Offer to have team members plan and/or conduct grand rounds education on prevention topics for hospitals. Encouraging safe sleep practices for infants should be a high priority topic.
- Provide cross training to all "in home" service providers (including parent mental health care providers and substance abuse counselors) on recognition of child abuse/neglect and child safety issues (including safe sleep practices) and the reporting process.
- Insure that training for soon to be and new parents includes information on safe sleep practices, child development, safe feeding, swaddling, and choosing day care providers. Encourage providers to use videos like the Eastern Virginia Medical School (EVMS) produced video on safe sleep when possible. **Encourage parents to not allow others to physically discipline their children.**
- Collaborate with programs that help parents because educating and supporting new parents is a critical piece of prevention. Whenever possible team members should partner with hospitals, EVMS, The Children's Hospital of The King's Daughters (CHKD) and coalitions like the Hampton Roads Home Visiting Alliance and the Hampton Roads Parenting Education Network to better communicate and spread the word.
- **Study attachment and particularly issues around parental addiction to Media devices and encourage the development of an educational initiative for parents around attachment and the importance of interpersonal interactions for infants and children.**

- Adopt a "bystander safety approach" to the recognition and reporting of child abuse. Educate the public that everyone is responsible for child safety.

Safe Sleep:

- **Require "in home" providers to view where infants are sleeping on every visit.**
- Advocate for the use of a "baby box" for infant sleep. Encourage health insurance companies, especially those serving Medicaid clients, to provide sleep boxes and safe sleep education for families of all new babies.
- Encourage the provision of safe sleep education – including information about safe swaddling techniques, to all caregivers - mothers, fathers, grandparents, siblings (especially if they are old enough to babysit), daycare providers (licensed and unlicensed), pediatricians, ER doctors, urgent care physicians, and home-based service providers. **Urge the use of short videos for this education whenever practical.**
- Continue and expand safe sleep campaigns as recommended in the past. Making significant cultural change takes time, persistence and on-going education for everyone. Keep reminding caretakers to put babies to sleep on their backs. Targeted efforts should be developed to educate male caretakers.
- Incorporate safe sleep education in all child care programs/classes and certifications. Also train child care providers to provide regular monitoring of sleeping children.
- Include information in all safe sleep education materials and trainings about infant anatomy and breathing patterns, the small size of infant nostrils, the impact of congestion and colds on small infants and how easy it is for them to suffocate. Incorporate information about the critical importance of putting sick and/or crying babies in safe sleep situations. These infants are at a higher risk of suffocating simply because of their immediate circumstances.
- Educate the public and professionals about safe swaddling techniques especially as related to safe sleep. Infants who are strong enough to break out of the swaddling blanket should be swaddled with their arms outside of the blanket.
- Don't put children (especially infants), to sleep in "Boppies, swings or car seats. Cribs need to be empty of toys, bumper pads, soft blankets, and pillows.
- Educate the public and professionals about the risk associated with placing children to sleep in closets or isolated places.
- **Emphasize that children should be easily and regularly monitored during sleep hours.**

Gun safety:

- Educate parents and professionals ***AND CHILDREN*** about gun safety and safe weapon storage, including storage lockers and keeping guns unloaded especially in households with children.

Water safety:

- Provide education around bath tub safety and general water safety for parents and caregivers.
- **Revisit community awareness around pool and tub safety for children. Remind the media, businesses and parent educators to keep water safety in the public eye especially as it relates to pools and tubs.**
- **Help to identify issues around distracted parenting such as cell phones and video games and encourage the development of messages to make parents more attentive to their children.**

Child care safety:

- Educate the public on how to choose and monitor child-care providers - especially family or household members.
- Continue to encourage the military to advocate for and/or provide adequate, affordable and accessible child care for military families.
- **Advocate for measures to monitor, establish safety requirements and educate unlicensed child care providers.**

Product safety:

- **Encourage the ongoing and updated education about choking on things like sausages and hot dogs; proper sizing and use of car seats; the danger of bean bag chairs and boppies; and diligent use of pool safety equipment.**

CONSUMER PRODUCT CHANGES SURROUNDING SAFE SLEEP

- Encourage the placement of consumer warnings about safe sleep practices on cribs, bassinets and playpens and in stores where baby sleep products are sold.
- Give positive acknowledgement to stores that are encouraging safe sleep practices.
- Support campaigns to provide safe sleep accommodations for struggling families.
- Monitor thrift stores and discourage the reuse of old or damaged cribs, playpens, car seats and other baby products that could be unsafe.

POLICY AND/OR SYSTEM REFORMS

Local

- Encourage Commonwealth Attorneys and police to consult across jurisdictional lines on strategies for more effective investigation and prosecution.
- Children who spend time in neonatal intensive care units (NICUs) are especially vulnerable. Every NICU should have a protocol to connect families at discharge with a service that will make at least one home visit after the child leaves the hospital. A Regional Centralized Intake process for Home Visitors has been created at the Planning Council to better coordinate a consistent point of entry into home visiting services across South Hampton Roads. Referrals to these services should be encouraged.

State

- **Change validity criteria. Make a category for short-term intake assessment and accounting and collection of data on all child fatalities. Mandate the investigation of all sleep related deaths, family annihilations, abandoned infants and children, and all unexplained or unexpected child deaths.** *(This is directed at establishing a process that insures the uniform collection of data across the state. It also anticipates future federal requirements as recommended in the report of the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) which was released in March of 2016.)*
- **Share with the state the "Suitability for the Placement of an Infant Checklist" developed by Norfolk and encourage other agencies to use it when placing infants with family or friends.**
- **Examine procedures for cases that involve more than one jurisdiction not only jurisdictions within the state but between states.**
- **Require Intake to always look up previous history on a call. Also check 9-1-1 calls if appropriate.**

- **Develop better screening Tools around early assessments for attachment. Include questions about - if the pregnancy was wanted or planned. Trauma assessment are important as well**
- **Implement the "Birth Match" program in Virginia. This program allows officials to match birth records with child maltreatment records in real time to enable social workers to check on newborns and assess whether protective interventions are warranted.** (*This is also a recommendation of CECANF.)*
- **Educate the public about safe haven laws. Continue to educate about and promote adoption.**
- **Require the state to develop a plan to monitor agencies for high turnover and high numbers of cases per worker. Require a state plan to offer assistance to struggling agencies.**
- **Explore the possibility of allowing new mothers to stay on Medicaid for a year postpartum.**
- Request that the State Department of Social Services study the intake practices around the state with the goal of creating policy that encourages more uniformity of response and data collection. Issues to be addressed include the entering of all screen outs into Oasis; creating a process to refer screen-outs that might require some services to a prevention unit; and looking at SDM tool changes that raise levels of concern based on the child's age, disability (if present), and child's isolation (such as not being in child care or in school).
- Encourage the Board of Social Services to develop a social service policy for small jurisdictions to help them better investigate child fatalities. (These policies should involve the regional consultants and include procedures for cross-agency investigations, emergencies and conflicts.)
- Reassess policy and training around social service safety plans. Make sure they are realistic, monitored, and that child safety is the FIRST priority. (The state of Florida reported an alarming increase in child abuse fatalities and one of the possible causes mentioned was the expanding emphasis on family reunification.)
- Develop more affordable, and more easily accessible, licensed day care options for families.
- Domestic violence, mental health issues and prior criminal behavior were significant factors in many of the homes where Hampton Roads children died from abuse or neglect. The Virginia Department of Social Services should continue to look at ways to better identify and assess the risk from these factors in families in which children are abused and neglected.
- Public assistance programs such as WIC, VIEW, SNAP, Medicaid and FAMIS should be encouraged to provide more prevention education around safe sleep, finding safe childcare, and domestic violence prevention to their clients with small children.
- There should also be a process created so that DSS workers can do timely criminal background checks. This is particularly important for child placement determinations.
- Educate local agencies and law enforcement about sharing records of death scene investigations such as the Center for Disease Control (CDC) Sudden Unexplained Infant Death (SUID) Investigation Reporting Form as authorized by Code.
- **Advocate for better teaming with law enforcement (as required by Code).**
  1.) Institutionalize the teaming processes. Particularly co-investigation (police and DSS) around fatal and near fatal deaths of children where child abuse or neglect may be an issue.
  2.) Create an efficient process that CPS workers can use to access criminal records of families and household members to use in investigations and when determining child placement options.
  3.) Require police to report all unexpected or unexplained child fatalities to Social Services for Social Services to take a look-see before rejecting a child for investigation. Establish procedures for a "look-see."
  4.) Make computer and phone checks regular part of police investigations in child fatalities

Federal

- **Create processes for more efficient "real time" record sharing by agencies across state lines.** Also important is the creation of processes for enabling services like Medicaid to follow families and children when they move across state lines.

SERVICES

- Request that the State Department of Social Services establish Prevention as a required service and ask for funding to add prevention staff.
- Advocate for more home-visiting services (such as CHIP, Healthy Families, and Parents as Teachers) to keep children safe in families with identified risks.
- Promote the importance of having adequate numbers of trained staff to enable social service agencies to do their jobs effectively and in a timely manner. Local agencies need adequate support and funding and more attention should be directed at this by government at all levels.
- Continue to advocate for affordable, accessible childcare (including weekend and evening care options) for all parents.

ISSUES IDENTIFIED FOR FUTURE STUDY

Social Work Training

Being a child protective service worker is difficult. Many agencies experience high rates of staff turnover which directly impacts the ability of the agency to protect children. Several recommendations address this problem.

- Universities that train social workers need to revise their programs so that graduates understand the nature of child social services and are prepared to do the work.
- The state should work with universities to revise their social work curricula and to develop protocols for insuring that CPS workers have proper on-the- job training for child related social services work.

Background Checks

Currently the state and local non-profits are exploring easier and more affordable strategies for completing background checks for professionals and volunteers working with children. As these strategies become more available, all parents should be encouraged to use these to screen their childcare providers.

REVIEW OF CURRENT (2016) LEGISLATIVE INITIATIVES

In the recent session of the Virginia General Assembly, there were several bills addressing problems identified by the team. Below is a list and brief description of those bills. (Note at the time of this report, all have passed the General Assembly, but several are still awaiting the Governor's signature.)

The information below is excerpted from the Voices for Virginia's Children website: *http://www.vakids.org/our-news/blog/starting-early-and-working-together-works-celebrating-progress-from-the-2016-ga-session*

Budget Items:

- **Significant expansion of home visiting parent and health education services-** The final budget includes additional TANF funding- an additional $9.5 M for Healthy Families, $2 M for CHIP and $2 M for Resource Mothers over the biennium. This funding more than doubles the current Healthy Families funding.
- **Increase to early intervention (Part C) services to keep pace with referrals**– The legislature accepted the Governor's proposal to increase state funds for early intervention by $1.7 M in FY17 and $2.5 M in FY18.
- **Child Care Workforce Scholarships-** The legislature recommended $600,000 the first year and $1.3 M the second for the creation of scholarships and a competency-based credentialing system through VECF.

Legislative Changes:

- **Established a criminal penalty if a child dies or is injured in unlicensed child care- "**Joseph's Law" (HB1198- Hester) continues the work from last session to improve the safety of child care.

Studies and Governance:

- **Workgroup to study health and safety in license-exempt child care**– This resolution (SJ63-Hanger) defines the stakeholders representing licensed and license-exempt child care to work with the Department of Social Services to review the health and safety standards of child care programs.
- **JLARC study of effective early childhood programs-** This resolution (SJ88- Norment) asks JLARC to do a two-year study of the early childhood programs in place in Virginia and make recommendations about the effectives of programs and options for aligning and improving programs.
- **Report on improving birth outcomes-** The Department of Health is asked to produce a report on the best methods or programs for improving birth outcomes, low birth weight, and out of wedlock births.

HAMPTON ROADS/ EASTERN REGIONAL CHILD FATALITY REVIEW TEAM
REPORT BACKGROUND
FY 2015 (July 1, 2014 - June 30, 2015)

INTRODUCTION

Concern for the welfare of children has been a longstanding matter of public interest. In 1974, the Federal government passed the Child Abuse Prevention and Treatment Act (CAPTA) and this created a defined policy regarding child abuse and neglect. States also began to more clearly define their positions in the field of child protection.

Since the early 1990's because of concerns about the well-being of children, a number of child fatality review teams have grown up around the country to study these deaths and to address prevention issues. Teams have grown up on both the state and local levels and they vary considerably in the type of data addressed, manner of review, and the prevention strategies employed.

THE VIRGINIA STATE CHILD FATALITY REVIEW TEAM

The Virginia State Child Fatality Review Team was established by the General Assembly in 1995. The purpose of the state Team "is to review child deaths in Virginia of children less that 18 years old to ensure that child deaths are analyzed in a systematic way . . ." The Team conducts death reviews to learn about the causes and circumstances of individual deaths in order to develop recommendations for prevention, education, and training that may reduce child deaths in the future." The first report of the state Team was a profile of all child deaths in Virginia in 1994 and an in-depth analysis of firearm fatalities among children and adolescents. In January 2000, the state Team released its report on suicide fatalities among children and adolescents during 1994-1995. The state Team released a report on unintentional injury deaths among Virginia's children, aged four and younger in December of 2001. The “Review of Caretaker Homicide and Undetermined Child Death” was published in May of 2005. These reports can be found on the Internet at: http://www.vdh.state.va.us/MedExam/index.htm

In 2014 the State Team released its report on Sleep-Related Infant Deaths in Virginia. The Team reviewed all deaths of infants less than one year of age that died unexpectedly in a sleep environment in Virginia (119) in calendar year 2009. The Office of the Chief Medical Examiner (OCME) has jurisdiction over the death of "any infant less than eighteen months of age whose death is suspected to be attributable to Sudden Infant Death Syndrome (SIDS now called Sudden Unexpected Infant Death or SUID)" and as such all 119 fatalities were autopsied and investigated by the OCME. The OCME divides the state into 4 districts Central, Northern, Tidewater and Western which are similar but not the same as the five Department of Social Services regions.

Key findings in this State report include:

Infants in Virginia's Western and Tidewater communities were at highest risk. Infants died in the Western region at a rate of 219.9 per 100,000 and in Tidewater, a rate of 155.2 per 100,000. These rates far surpassed the state rate of 111.3 per 100,000.

- *The State Team concluded that 95% of these deaths were preventable and 90% were related to an unsafe sleep environment.*

- *More than 70% of the infants in this review were exposed to secondhand smoke. Half of the mothers smoked while pregnant with the infant who died.*

- *More than half of the infants who died were co-sleeping with at least one other person. Of those infants who were co-sleeping, almost a quarter had at least one co-sleeper who had used alcohol or drugs.*

- *One in five mothers used alcohol or drugs while pregnant with the infant who died.*

- *Consistent with national data findings, Black male infants four months of age and younger at most at risk of sleep-related death. Black infants died at a rate more than twice that of White infants. Male infants died at a rate more than 1.5 times that of female infants. Three out of four infants who died were four months of age or younger.*

- *Fewer than half of the infants were placed on their backs for sleep. More than half were found on their stomachs.*

- *Ninety-eight percent of infants had been seen by a pediatrician since birth. Seventy-two percent had seen a pediatrician in the 30 days preceding their death.*

- *Three-quarters of the families in this review had a crib, bassinette or portable crib available. About one quarter of the infants were sleeping in one of these locations at the time of their death.*

- *At least one caregiver was impaired by alcohol or drugs in almost one quarter of the cases in this review.*

The full state report can be found at http://www.vdh.virginia.gov/medExam/childfatality-reports.htm

VIRGINIA CHILD FATALITIES AS A RESULT OF CHILD ABUSE OR NEGLECT

The Virginia Department of Social Services is mandated by statute to investigate child abuse and neglect by parents or caretakers.

"To be investigated by CPS a child fatality has to meet the following criteria:

1. The child has died at the hands of a parent or caretaker; or

2. Because the parent or caretaker failed to provide adequate supervision or medical attention for the child."

The state report for previous years can be found on the Internet at:
http://www.dss.virginia.gov/geninfo/reports/children/index.html

CPS fatality statistics include only fatalities that are due to abuse or neglect by a parent or caretaker. Deaths due to physical abuse are the result of inflicted injuries. Deaths due to neglect are the result of the responsibility or irresponsibility of a caretaker. Medical neglect is found in situations when, through an act of omission, a caretaker fails to take a child for medical attention in a timely manner.

THE EASTERN REGION CHILD FATALITY REVIEW TEAM

The Eastern Region Child Fatality Review Team was created as the result of an organizational meeting held on August 9, 1994. The meeting was convened by the Hampton Roads Committee to Prevent Child Abuse (AKA Prevent Child Abuse Hampton Roads and Champions for Children) and The Children's Hospital of The King's Daughters with the purpose of studying child fatalities in the region and developing appropriate prevention strategies to address identified concerns. Attending this meeting were twenty individuals from around the region representing social services, a regional children's hospital, a health district, a commonwealth attorney's office, a children's advocacy group and the medical examiner's office.

The Virginia Department of Social Services Eastern Region served by the Team is large and diverse. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, and Franklin. It also includes the counties of Accomack, Isle of Wight, Surry, Southampton, Northampton, James City, and York-Poquoson. The regional lines are moved sporadically by the state and during the years the region has grown to include Brunswick, Dinwiddie, Gloucester, Greenville, Mathews, Prince George and Sussex Counties. Currently there are 23 agencies in the Eastern Region.

The Team is comprised of a core group of members representing various related professions and regions. The Regional Child Protective Services Consultant currently chairs the Team and a social service representative from each locality serves as a designated member. A District Medical Examiner is also a core Team member. Other attendees represent the medical community, law enforcement, the legal community, the military, the Children’s Hospital of The King’s Daughters (CHKD) Child Abuse Program and child advocacy groups. With each review, additional people from the locality of the death join the Team to review the case.

The purpose of the Team is to accurately identify and document the causes of child death, to collect uniform and accurate statistics on child death, to coordinate efforts among participating agencies, to identify circumstances surrounding deaths that could be prevented in the future, to improve criminal investigation and prosecution of child abuse homicides, to design and implement cooperative protocols for investigation of certain categories of child death, to improve communication among agencies, to provide a safe, confidential forum for agency representatives

to talk with each other and resolve conflicts among the agencies, to generate needed changes in legislation, policy and practice and to identify public health issues and recommendations.

The Eastern Region Child Fatality Review Team currently reviews cases of child death that have been investigated by the local social service agencies because of suspected abuse or neglect by a caretaker leading to the death. A number of the cases reviewed have been founded but many of the cases reviewed were determined unfounded meaning that the investigation of the death did find evidence to support a finding that the death was caused by abuse or neglect.

By law, the proceedings of the individual reviews are confidential and the information compiled as a result of the work of the Team can be made public only in the form of statistics that contain no personal identifying information.

PREVENTION STRATEGIES

As a result of the case reviews and findings, over the years the Team has made recommendations and initiated programs and projects to help prevent future fatalities.

The Team has continued to improve record keeping and has recommended better processes to facilitate communications between the various agencies in order to enhance the collection of more complete, timely, and legally relevant information. A current project of the Team is the encouraging the use of best practice protocols and forms for agencies and death scene investigations of child fatalities throughout the region. Data collection methodology is being implemented to generate more detailed information and to be part of other similar state and national data collection projects. In the future, it is anticipated that more detailed data analysis will be available through the national data collection system (National Center for Child Death Review, *Child Death Review Case Reporting System)* that the state began using starting with FY 11 cases.

Over the years, many new strategies to better educate parents and the public regarding child safety and health and child development issues have been explored and implemented. Because of the high percentage of deaths and children left in vegetative or disabled states from abusive head trauma, an innovative Shaken Baby Awareness Campaign was implemented by the Navy and the Children’s Hospital of The King’s Daughters. In addition, videos have been purchased and placed in physician's offices, departments of social services, hospitals, and libraries to help people understand the seriousness of this type of injury. Members of the Team have participated in prevention trainings on the national, state and local levels. In addition, the Team has provided training not only locally but around the state. A number of Team agencies have been working to get prevention messages out to their clients as well as the public at large. The Children's Hospital of The King's Daughters (CHKD) developed and distributes a series of informational cards for caretakers that address a number of child safety concerns identified by the Team. CHKD and Prevent Child Abuse Hampton Roads (Champions for Children) sponsor programs and publish information for both parents and professionals aimed at preventing child fatalities.

Collaborations with a number of community groups and agencies such as the Virginia Department of Social Services, CHKD, the United States Navy, Eastern Virginia Medical School (EVMS), Healthy Families Hampton Roads, CHIP, the Child Abuse Program at CHKD, the Suburban Junior Woman's Club, Chesapeake General Hospital, KidsPriorityOne and Prevent Child Abuse Hampton Roads have helped to enhance the Team's prevention efforts.

Child fatalities from abuse or neglect are preventable and Team members are involved in on-going efforts to raise community awareness about the issues, educate parents and to make everyone a partner in prevention. Team members regularly conduct workshops for professionals, parents, and other community members.

The Team developed and continues to distribute a multi-faceted public awareness campaign to acknowledge that parenting is hard; it is good to ask for help and to call 1-800-CHILDREN, a free statewide information line, to get help. Because most of the child fatalities reviewed occurred to children under the age of one, the campaign targets young parents of newborns.

In response to the increasing number of children in the region dying in unsafe sleep environments, members of the Team worked with Eastern Virginia Medical School (EVMS) to produce a short educational video on the dangers of unsafe sleep practices and how to safely put babies to sleep. This video was made available to view or download on line and was distributed not only in Hampton Roads, but around the state and, via a SUID (Sudden Unexpected Infant Death) email list, around the world. Many hospitals, doctors' offices, health departments, departments of human services and home-visiting programs are using this film as part of their programming.

The Team continues to spread safe sleep messages through trainings, multiple public awareness/media platforms and an increasing number of partnerships.

In 2014, the Team received the Voices for Virginia's Children Carol S. Fox Making Kids Count Award in the organization category. The Award is for "an organization that has made exceptional contributions to improving the lives of children in Virginia." In 2015, the Team received the Family and Children's Trust (FACT) Team Child Welfare Certificate of Appreciation Award. This award honors groups whose prevention, intervention and treatment efforts in the area of child abuse and neglect have shown exceptional merit.

In addition this year, the Team in partnership with the Virginia Department of Health has received a grant from the CDC to study Sudden Death in the Young in the Cities of Hampton, Newport News, Norfolk, and Virginia Beach. The purpose of the grant is to conduct more intensive death investigations and fatality reviews to see if causes of death can be clarified in cases where cause of death to infants, youth and children (0-19 years old) cannot be determined with medical certainty. Examples include sudden deaths associated with cardiac problems, epilepsy, and infant sleep environments.

APPENDIX I

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2015

There were a total of 13 child fatalities founded as a result of abuse or neglect. Note: A total of 15 abusers were identified for these 12 cases. In the deaths of 11 children, one abuser was identified. Two cases involved a second abuser.

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
3	4	2	2	2	13

Fatality by Child's Sex

Female	Male	Total
9	4	13

Fatality by Child's Race

Caucasian	African - American	Hispanic	Asian	Biracial	Unknown	Total
5	8	0	0	0	0	13

Fatality by Jurisdiction

Chesapeake	Dinwiddie	Franklin	Hampton	Isle of Wight	Norfolk	Portsmouth	Suffolk	Virginia Beach	York	Total
0	0	0	2	1	2	3	1	3	1	13

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
5	8	13

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Gunshot	Other	Total
0	3	1	0	1	0	5

Fatality by Cause of Death (Neglect)

Inadequate Supervision Asphyxiation	Inadequate Supervision Drowning	Inadequate Supervision Caretaker DUI	Medical Neglect	Undetermined	Total
1	5	0	0	2	8

Fatality by Previous Social Services Contact

Previous DSS Contact	Screen Out	Total
5	2	7

Fatality by Sex of Perpetrator

Female	Male	Unknown	Total
8	7	0	15

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
7	3	0	8

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
1	4	0	7

Fatality by Race of Perpetrator

African-American	Caucasian	Asian	Unknown	Total
9	6	0	0	15

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	3	4	1	2	4	0	15

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Mother	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Total
6	6	0	1	1	1	0	0	15

Cases (Child) in Which Criminal Charges Were Filed *(information incomplete)*

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Total
6	1?	5	1	0	13

Jurisdictions Where Charges Were Filed

Hampton	Isle of Wight	Norfolk	Portsmouth	Virginia Beach	York	Total
1	0	1	1	2	1	6

APPENDIX II

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2014

There were a total of 17child fatalities founded as a result of abuse or neglect. Note: A total of 22 abusers were identified for these 17 cases. In the deaths of 11 children, one abuser was identified. Four cases involved a second abuser and one death involved three abusers.

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	2	1	2	6	17

Fatality by Child's Sex

Female	Male	Total
9	8	17

Fatality by Child's Race

Caucasian	African - American	Hispanic	Asian	Biracial	Unknown	Total
6	8		1	2		17

Fatality by Jurisdiction

Chesapeake	Dinwiddie	Franklin	Hampton	James City	Norfolk	Portsmouth	Surry	Virginia Beach	Total
1	1	2	3	1	4	2	1	2	17

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
11	6	17

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Gunshot	Other	Total
1	5	1	1	1	2	11

Fatality by Cause of Death (Neglect)

Inadequate Supervision Overdose	Inadequate Supervision Unsafe Sleep	Inadequate Supervision Caretaker DUI	Medical Neglect	Total
2	1	1	2	6

Fatality by Previous Social Services Contact

Previous DSS Contact	Total
7	7

Fatality by Sex of Perpetrator

Female	Male	Unknown	Total
13	9		22

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
6	4		10

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
7	5		12

Fatality by Race of Perpetrator

African-American	Caucasian	Asian	Unknown	Total
12	8	1	1	22

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
0	8	2	3	2	4	3	22

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Mother	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Total
7	10	1		2			2	22

Cases (Child) in Which Criminal Charges Were Filed*

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Total
9	?	5	1		17

**Information incomplete*

Jurisdictions Where Charges Were Filed

Dinwiddie	Franklin	Hampton	Norfolk	Portsmouth	Suffolk	Total
1	1	1	4	2		9

APPENDIX III

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2013

There were a total of 12 child fatalities founded as a result of abuse or neglect. (Four uncounted cases are under appeal.) In five cases more than one perpetrator was responsible for the death of a single child. *(The findings in this chart are preliminary and will be updated when the case dispositions are finalized.)*

Fatality by Child's Age

<1yr.	1yr	2yrs.	3yrs.	4+yrs.	Total
4	4	1	0	3	12

Fatality by Child's Sex

Male	Female	Total
6	6	12

Fatality by Child's Race

Caucasian	African - American	Hispanic/White	Biracial	Unknown	Total
7	5	0	0	0	12

Fatality by Jurisdiction

Accomack	Chesapeake	Greensville Emporia	Hampton	Newport News	Norfolk	Isle of Wight	Suffolk	Virginia Beach	Total
1	3	1	1	3	0	0	0	3	12

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
8	4	12

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Drowning	Inflicted Traumatic Brain Injury	Blunt Force Trauma	Gunshot	Poisoning	Stabbing	Undetermined	Total
0	0	0	8	0	0	0	0	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Suffocation	Medical Neglect	Abandon-ment	Dehydration Malnutrition	Undetermined	Total
1	1	0	0	0	0	0	2	4

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Unknown	Total
6	0	0	6

Fatality by Previous Criminal Record

Criminal Record	Criminal Status Undetermined	Total
5	7	12

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
12	4	0	16

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
3	4	0	7

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
9	8	1	18

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
7	10	1	18

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	7	1	3	1	4	1	18

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Adoptive Grand-father	Other Relative	Mother's Paramour	Child Care Provider	Adoptive Parent	Unknown	Total
4	6	1	0	2	2	2	1	18

APPENDIX IV

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2012

There were a total of 16 child fatalities founded as a result of abuse or neglect. (One uncounted case is under appeal.) Two perpetrators were responsible for the death of more than one child and in three cases more than one perpetrator was responsible for the death of a single child.

Fatality by Child's Age

<1yr.	1yr	2yrs.	3yrs.	4+yrs.	Total
6	3	2	0	5	16

Fatality by Child's Sex

Male	Female	Total
7	9	16

Fatality by Child's Race

Caucasian	African - American	Hispanic/White	Biracial	Unknown	Total
4	9	2	1	0	16

Fatality by Jurisdiction

Accomack	Chesapeake	Hampton	Newport News	Norfolk	Isle of Wight	Suffolk	Surry	Virginia Beach	Total
2	0	1	3	3	1	1	1	4	16

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
12	4	16

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Drowning	Inflicted Traumatic Brain Injury	Blunt Force Trauma	Gunshot	Poisoning	Stabbing	Undetermined	Total
2	1	0	4	2	0	3		12

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Poisoning	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Suffocation	Medical Neglect	Abandon-ment	Dehydration Malnutrition	Undetermined	Total
1	1	0	0	0	0	0	2	4

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Unknown	Total
5	0	0	5

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
12	4	0	16

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
3	4	0	7

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
1	8	0	9

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
11	4	1	16

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
0	8	0	3	4	1	0	16

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Foster Parent	Unknown	Total
5	3	1	1	6	0	0	0	16

APPENDIX IV-A

CHILD FATALITIES-UNFOUNDED-EASTERN REGION-FY 2012
There were a total of 39 child fatalities unfounded as a result of abuse or neglect.

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
31	0	3	2	3	39

Fatality by Child's Sex

Male	Female	Total
21	18	39

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
11	27	0	1	0	39

Fatality by Jurisdiction

Brunswick	Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Suffolk	Sussex	York Poquoson	Virginia Beach	Total
1	1	3	10	6	4	6	1	2	5	39

Fatality by Cause of Death

Asphyxiation	Illness/Physical Impairment	SIDS	SUIDS	Drowning	Hit by Car	Undetermined	Total
7	7	0	12	3	1	9	39

Fatality by Previous Social Services Contact

Previous DSS Contact	None Known	Total
9	30	39

Fatality by Family Receiving Public Assistance

Family on One or More Public Assistance Programs	None Known	No Information	Total
22	14	3	39

25 children died in unsafe sleeping environments.

APPENDIX V

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2011
There were a total of 10 child fatalities founded as a result of abuse or neglect.

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
5	3	0	0	2	10

Fatality by Child's Sex

Male	Female	Total
8	2	10

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
5	3	0	2	0	10

Fatality by Jurisdiction

Chesapeake	Hampton	Newport News	Norfolk	Isle of Wight	Gloucester	York Poquoson	Virginia Beach	Total
1	2	2	1	1	1	1	1	10

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
8	2	10

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Gunshot	Poisoning	Total
1	5	0	0	0	2	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Choking	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Suffocation	Medical Neglect	Abandon-ment	Dehydration Malnutrition	Other	Total
1	0	0	0	1	0	0	0	2

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Unknown	Total
4	0	0	4

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
7	3	0	10

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
0	2	0	2

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
4	4	0	8

Fatality by Race of Perpetrator

African-American	Caucasian	Biracial	Total
3	6	1	10

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	3	3	3	0	0	0	10

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Foster Parent	Unknown	Total
5	3	0	0	2	0	0	0	10

APPENDIX V-A

CHILD FATALITIES-UNFOUNDED-EASTERN REGION-FY 2011
There were a total of 30 child fatalities unfounded as a result of abuse or neglect.

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
26	0	2	1	1	30

Fatality by Child's Sex

Male	Female	Total
23	7	30

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
13	17	0	0	10	30

Fatality by Jurisdiction

Accomack	Chesapeake	Hampton	Newport News	Norfolk	Dinwiddie	Portsmouth	York Poquoson	Virginia Beach	Total
1	4	4	9	1	1	3	1	6	30

Fatality by Cause of Death

Asphyxiation	Illness/Physical Impairment	SIDS	SUIDS	Drowning	Poisoning	Undetermined	Total
2	6	1	15	3	0	3	30

Fatality by Previous Social Services Contact

Previous DSS Contact	None Known	Total
9	21	30

Fatality by Family Receiving Public Assistance

Family on One or More Public Assistance Programs	None Known	Total
17	13	30

APPENDIX VI

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2010

There were a total of 16 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of six children, there was more than one caretaker founded for abuse or neglect making a total count of 24 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
9	2	3	1	1	16

Fatality by Child's Sex

Male	Female	Total
10	6	16

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
9	7	0	0	0	16

Fatality by Jurisdiction

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Accomack	Greensville County	Prince George	Virginia Beach	Total
2	0	3	5	0	1	1	1	3	16

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
8	8	16

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Gunshot	Other	Total
0	7	0	0	1	0	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Choking	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Suffocation	Medical Neglect	Abandon-ment	Dehydration Malnutrition	Other	Total
2	1	0	0	0	0	1	4	8

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Unknown	Total
5	0	1	6

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
10	13	1	24

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
9	4		13

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
4	6	1	11

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
12	11	1	24

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	8	8	1	2	2	2	24

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Foster Parent	Unknown	Total
6	6	0	1	5	4	1	1	24

Cases (Child) in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Unknown	Total
13	0	2	0	0	1	13

Charges Not Prosecuted

Physical Neglect	Physical Abuse	Physical Abuse Abuser Committed Suicide	Physical Neglect Abuser Unknown	Unknown	Total
2	0	0	0	1	3

Jurisdictions Where Charges Were Filed

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Accomack	Greensville County	Prince George	Virginia Beach	Total
2	0	1	5	0	1	1	1	2	13

APPENDIX VII

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2009

There were a total of 16 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of six children, there was more than one caretaker founded for abuse or neglect making a total count of 33 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	2	1	1	6	16

Fatality by Child's Sex

Male	Female	Total
5	11	16

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
7	9	0	0	0	16

Fatality by Jurisdiction

Chesapeake	Hampton	Newport News	Norfolk	James City County	Suffolk	York Poquoson	Sussex County	Prince George County	Isle of Wight	Virginia Beach	Total
1	1	1	5	1	1	1	1	1	1	2	16

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
7	9	16

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Inflicted Blunt Force Trauma	Drowning	Stabbing	Other	Total
0	3	2	0	1	1	7

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Suffocation	Medical Neglect	Abandon-ment	Malnutrition	Other	Total
3	0	0	4	0	0	1	1	9

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Total
3		3

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
12	10	1	23

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
7	6		13

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
4	5	1	10

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
14	8	1	23

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	8	7	1	1	3	2	23

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Institution Caretaker	Unknown	Total
6	7	2	4	0	3	0	1	23

Cases (Child) in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unidentified	Unknown	Total
10	0	2	0	2	2	16

Charges Not Prosecuted

Physical Neglect	Physical Abuse	Physical Abuse Abuser Committed Suicide	Physical Abuse Abuser Unidentified	Total
2	0	0	2	4

Jurisdictions Where Charges Were Filed

Chesapeake	Hampton	Newport News	Norfolk	James City County	Suffolk	York Poquoson	Sussex County	Prince George County	Isle of Wight	Virginia Beach	Total
1	1	1	3	1	1	1	U	U	0	1	12

APPENDIX VIII

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2008

There were a total of 11 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of four children, there was more than one caretaker founded for abuse or neglect making a total count of 15 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	2	1	0	2	11

Fatality by Child's Sex

Male	Female	Total
7	4	11

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
5	5	0	1	0	11

Fatality by Jurisdiction

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Suffolk	James City County	Sussex	Virginia Beach	Total
3	1	1	1	1	1	1		2	11

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
5	6	11

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Total
0	4	1	0	5

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Suffocation	Inadequate Supervision Asphyxiation Hyperthermia	Medical Neglect	Car Accident	Malnutrition	Total
1	1	2	0	0	1	1	6

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Total
3	-	3

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
9	6	0	15

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
6	2	0	8

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
2	5	0	7

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
10	5	0	15

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
4	3	3	4	0	1	0	15

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Foster Parent	Unknown	Total
8	4	0	0	0	2	1	0	15

Cases (Child) in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Unknown	Total
5	0	3	0	0	3	11

Charges Not Prosecuted

Physical Neglect	Physical Abuse	Physical Abuse Abuser Committed Suicide	Physical Neglect Abuser Unidentified	Unknown	Total
2	0	0	1	3	6

Jurisdictions Where Charges Were Filed

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Suffolk	James City County	Sussex	Virginia Beach	Total
0	1	0	1	1	U	1	0	1	5

APPENDIX IX

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2007

There were a total of 9 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of three children, there was more than one caretaker founded for abuse or neglect making a total count of 12 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
3	2	1	1	2	9

Fatality by Child's Sex

Male	Female	Total
7	2	9

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
5	2	0	2	0	9

Fatality by Jurisdiction

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Franklin City	Dinwiddie	Sussex	Virginia Beach	Total
1	1	1	1	1	1	1	1	1	9

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
4	5	9

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Stabbing	Poisoning	Total
1	0	1	0	1	1	4

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Fire	Inadequate Supervision Asphyxiation Hyperthermia	Medical Neglect	Abandon-ment	Dehydration	Total
3	0	1	0	1	0	0	5

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Total
2	0	2

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
5	7	0	12

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
4	2	0	6

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
3	3	0	6

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
3	9	0	12

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
0	3	5	1	2	1	0	12

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Child Care Provider	Institution Caretaker	Unknown	Total
4	7	1	0	0	0	0	0	12

Cases (Child) in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Total
3	0	0	0	0	3

Charges Not Prosecuted

Physical Neglect	Physical Abuse	Physical Abuse Abuser Died	Physical Neglect Abuser Unknown	Unknown	Total
0	0	1	0	3	4

Jurisdictions Where Charges Were Filed

Chesapeake	Hampton	Newport News	Norfolk	Portsmouth	Franklin City	Dinwiddie	Sussex	Virginia Beach	Total
0	0	U	U	1	U	1	1	X	3

APPENDIX X

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2006

There were a total of 13 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of six children, there was more than one caretaker founded for abuse or neglect making a total count of 20 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
7	1	4	0	1	13

Fatality by Child's Sex

Male	Female	Total
8	5	13

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
6	7	0	0	0	13

Fatality by Jurisdiction

Accomack	Chesapeake	Hampton	Isle of Wight	Newport News	Norfolk	Portsmouth	Suffolk	Virginia Beach	Total
1	1	1	1	0	4	1	1	3	13

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
8	5	13

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Snapped Neck	Total
1	6	0	1	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Dog Bites	Inadequate Supervision Asphyxiation Hyperthermia	Medical Neglect	Abandon-ment	Inadequate Supervision Undetermined	Total
0	0	1	0	0	1	3	5

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Unknown	Total
7	0	1	8

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
8	11	1	20

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
5	5	1	11

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
4	5	0	9

Fatality by Race of Perpetrator

African-American	Caucasian	Native American	Unknown	Total
10	8	1	1	20

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	6	6	2	0	3	2	20

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Other	Total
5	4	0	3	4	2	0	1	1	20

APPENDIX XI

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2005

There were a total of 9 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of three children, there was more than one caretaker founded for abuse or neglect making a total count of 12 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	2	1	0	0	9

Fatality by Child's Sex

Male	Female	Total
3	6	9

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
3	5	0	1	0	9

Fatality by Jurisdiction

Chesapeake	Hampton	Isle of Wight	Newport News	Norfolk	Portsmouth	Suffolk	Southamp -ton	Sussex	Virginia Beach	Total
1	2	1	1	2	0	0	0	0	2	9

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
7	2	9

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Inflicted Traumatic Brain Injury	Internal Injuries	Drowning	Total
2	4	0	1	7

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Poisoning	Inadequate Supervision Suffocation	Medical Neglect	Abandon- ment	Dehydration	Total
0	0	1	1	0	0	0	2

Fatality by Previous Social Services Contact

Previous DSS Contact	Called /Not Taken	Total
4	0	4

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
5	7	0	12

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
4	0	0	4

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
3	5	0	8

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
7	5	0	12

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
2	6	2	1	0	1	0	12

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Total
2	6	0	0	3	1	0	0	12

APPENDIX XII

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2004

There were a total of 12 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of three children, there was more than one caretaker founded for abuse or neglect making a total count of 16 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	2	2	0	3	13

Fatality by Child's Sex

Male	Female	Total
7	6	13

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
2	10	1	0	0	13

Fatality by Jurisdiction

Chesapeake	Newport News	Norfolk	Portsmouth	Southampton	Sussex	Virginia Beach	Total
2	3	4	1	1	1	1	13

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
8	5	13

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Gunshot	Inflicted Traumatic Brain Injury	Scalding	Internal Injuries	Drowning	Total
2	2	3	1	0	0	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Fire	Inadequate Supervision Gunshot	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Hyperthermia	Medical Neglect	Abandon-ment	Dehydration	Total
1	2	0	0	0	2	0	0	5

Fatality by Previous Social Services Contact (Perpetrator)

Previous DSS Contact	Called /Not Taken	Total
12	1	13

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
6	11	0	17

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
6	2	0	7

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
5	4	0	9

Fatality by Race of Perpetrator

African-American	Caucasian	Hispanic	Unknown	Total
14	2	1	0	17

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
2	7	0	1	1	6	0	17

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Total
5	9	0	1	2	0	0	0	17

APPENDIX XIII

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2003

There were a total of 20 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of five children, there was more than one caretaker founded for abuse or neglect making a total count of 30 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
11	2	2	1	4	20

Fatality by Child's Sex

Male	Female	Total
13	7	20

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
8	11	0	1	0	20

Fatality by Jurisdiction

Virginia Beach	Norfolk	Newport News	Ports-mouth	Chesapeake	Hampton	James City Co.	Isle of Wight	Suffolk	Total
4	8	3	0	3	1	0	0	1	20

Fatality by Primary Social Service Finding

Physical Abuse	Physical Neglect	Total
12	8	20

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Head Trauma	Internal Injuries	Drowning	Total
1	4	3	4	12

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Suicide	Inadequate Supervision Asphyxiation Hyperthermia	Medical Neglect	Abandon-ment	Dehydration	Total
1	1	1	1	1	1	2	8

Fatality by Previous Social Services Contact

Previous DSS Contact	No Recorded DSS Contact	Called /Not Taken	Total
5	15	0	20

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
11	18	1	30

Neglect by Sex of Perpetrator

Female	Male	Unknown	Total
11	5	1	17

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
7	6	0	13

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
20	9	1	30

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	15	3	3	0	5	3	30

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Sitter	Institution Caretaker	Unknown	Total
6	11	0	4	2	2	4	1	30

Cases (Child) in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Total
10	0	5	4	1	20

Charges Not Prosecuted

Physical Neglect	Physical Abuse	Physical Abuse Abuser Committed Suicide	Physical Neglect Abuser Unknown	Total
4	1	4	1	10

Jurisdictions Where Charges Were Filed

Military	Virginia Beach	Norfolk	Newport News	Suffolk	Hampton	Total
1	2	4	1	1	1	10

APPENDIX XIV

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2002

There were a total of 13 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of three children, there was more than one caretaker founded for abuse or neglect making a total count of 18 abusers.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
5	1	2	2	3	13

Fatality by Child's Sex

Male	Female	Total
8	5	13

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
4	8	0	1	0	13

Fatality by Jurisdiction

Virginia Beach	Norfolk	Newport News	Ports-mouth	Chesapeake	Hampton	James City Co.	Isle of Wight	Suffolk	Total
3	3	1	2	3	1	0	0	0	13

Fatality by Primary Social Service Finding (on Abuser)

Physical Abuse	Physical Neglect	Total
5	13	18

Fatality by Cause of Death (Physical Abuse)

Shaken Baby	Head Trauma	Internal Injuries	Gunshot	Total
0	1	2	2	5

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Smoke Inhalation (Fire)	Inadequate Supervision Asphyxiation	Medical Neglect	Abandon-ment	Inadequate Supervision Poisoning	Total
2	2	0	1	1	2	0	8

Fatality by Previous Social Services Contact

Previous DSS Contact	No Recorded DSS Contact	Called /Not Taken	Total
6	7	0	13

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
8	10	0	18

Neglect by Sex of Perpetrator

Female	Male	Total
9	4	13

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
1	4	0	4

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
7	11	0	18

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
4	3	4	3	1	2	1	18

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Paramour	Sitter	Foster-Caretaker	Unknown	Total
5	4	0	1	2	1	5	0	18

Cases in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed	Charges Not Filed Abuser Committed Suicide	Charges Not Filed Abuser Unknown	Total
7	0	9	2	0	18

Charges Not Prosecuted

Physical Neglect	Physical Abuse Abuser Committed Suicide	Physical Abuse Abuser Unknown	Total
9	2	0	11

Localities Where Charges Were Filed

Portsmouth	Virginia Beach	Norfolk	Newport News	Tennessee	Total
3	1	1	1	1	7

APPENDIX XV

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 2001

There were a total of 10 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of two children there were two caretakers founded for neglect making a total of 12 perpetrators*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
6	0	1	3	0	10

Fatality by Child's Sex

Male	Female	Total
9	1	10

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
3	5	0	2	0	10

Fatality by Jurisdiction

Virginia Beach	Norfolk	Newport News	Ports-mouth	Chesapeake	Hampton	James City Co.	Isle of Wight	Suffolk	Total
4	1	1	2	0	1	1	0	0	10

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Medical Neglect	Total
3	7	1	10

Fatality by Cause of Death (Physical Abuse)

Shaken Baby	Head Trauma	Internal Injuries	Total
1	1	1	3

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Smoke Inhalation (Fire)	Inadequate Supervision Asphyxiation	Medical Neglect	Inadequate Supervision Poisoning	Total
1	1	1	2	1	1	7

Fatality by Previous Social Services Contact

Previous DSS Contact	No Recorded DSS Contact	Called /Not Taken	Total
1	11	0	12

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
5	6	1	12

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
5	6	1	12

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
1	2	2	0	0	6	1	12

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Other Relative	Boyfriend	Sitter	Unknown	Total
3	3	0	3	1	1	1	12

Cases in Which Criminal Charges Were Filed

Charges Filed	Charges Pending	Charges Not Filed Abuser Unknown	Charges Not Filed	Total
3	1	1	5	10

Charges Not Prosecuted

Physical Neglect	Physical Abuse Abuser Unknown	Total
5	1	6

Neglect Case by Sex of Perpetrator

Female	Male	Total
5	4	9

Physical Abuse by Sex of Perpetrator

Female	Male	Abuser Unknown	Total
1	1	1	3

Cities Where Charges Were Filed

Hampton	James City County	Norfolk	Portsmouth
1	2	1	1

APPENDIX XVI

CHILD FATALITIES-EASTERN REGION-FY 2000

There were a total of 17 child fatalities. *Note: In the death of one child there were three caretakers (mom, mom's boyfriend, and the sitter) were founded and convicted for neglect and/or abuse making a total of 19 perpetrators*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
7	8	0	0	2	17

Fatality by Child's Sex

Male	Female	Total
10	7	17

Fatality by Child's Race

Caucasian	African - American	Hispanic	Biracial	Unknown	Total
6	11	0	0	0	17

Fatality by Jurisdiction

Virginia Beach	Norfolk	Newport News	Ports-mouth	Chesa-peake	Hampton	James City Co.	Isle of Wight	Suffolk	Total
4	3	3	2	1	1	1	1	1	17

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Total
13	4	17

Fatality by Cause of Death (Physical Abuse)

Shaken Baby	Head Trauma	Internal Injuries	Immersion Burns	Dismembered	Total
5	3	3	1	1	13

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision Gunshot	Inadequate Supervision Suffocated (Fire)	Total
2	1	1	4

Fatality by Previous Social Services Contact

Previous DSS Contact	No Recorded DSS Contact	Called /Not Taken	Total
6	11	1	17

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
15	4	0	19

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
11	8	0	19

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
3	7	4	2	2	1	0	19

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Boyfriend	Sitter	Unknown	Total
5	4	3	5	2	0	19

Criminal Charges Filed

Charges Filed	No Charges Filed	Charges Filed/Dropped	Defendant At-Large	Total
16	1	1	1	19

Charges Not Prosecuted

Physical Neglect	Total
2	2

Neglect Case by Sex of Perpetrator

Female	Male	Total
3	1	4

Physical Abuse by Sex of Perpetrator

Female	Male	Total
1	14	15

APPENDIX XVII

CHILD FATALITIES-EASTERN REGION-FY 1999

There were a total of 11 child fatalities. *Note: In the death of two children both caretakers (aunt and uncle) were founded for neglect making a total of 13 perpetrators*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
3	2	2	1	3	11

Fatality by Child's Sex

Male	Female	Total
7	4	11

Fatality by Child's Race

Caucasian	African American	Hispanic	Biracial	Unknown	Total
3	6	0	1	1	11

Fatality by Jurisdiction

Virginia Beach	Norfolk	Prince George	Hampton	Portsmouth	York - Poquoson	Total
4	2	2	1	1	1	11

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Total
8	3	11

Fatality by Cause of Death (Physical Abuse)

Shaken Baby Syndrome	Internal Injuries	Internal Injuries Gunshot	Total
3	4	1	8

Fatality by Cause of Death (Neglect)

Inadequate Supervision Drowning	Inadequate Supervision DUI	Abandoned At Birth	Total
1	1	1	3

Fatality by Previous Social Services Contact

Previous DSS Contact	No DSS Contact	Unknown	Total
5	5		11

Fatality by Sex of Perpetrator

Male	Female	Unknown	Total
7	5	1	13

Fatality by Race of Perpetrator

African-American	Caucasian	Unknown	Total
9	3	1	13

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
0	5	4	2	0	1	1	13

Fatality by Role of Perpetrator/Caretaker

Father	Mother	Step-Father	Aunt	Uncle	Unknown	Total
4	3	1	2	2	1	13

Criminal Charges Filed

Charges Filed	No Charges Filed	Total
11	2	13

Charges Not Filed

Physical Neglect	Abandonment	Total
1	1	2

Neglect Case by Sex of Perpetrator

Female	Unknown	Total
2	1	3

Physical Abuse by Sex of Perpetrator

Female	Male	Total
3	7	10

APPENDIX XVIIi

CHILD FATALITIES-EASTERN REGION-FY 1998

There were a total of 20 child fatalities. *Note: In the death of 1 child both parents were founded for neglect making a total of 21 perpetrators and 3 perpetrators had dual social service findings (i.e. physical abuse and medical neglect). This will cause some of the totals to exceed the number of 20 children.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
10	3	4	2	1	20

Fatality by Child's Sex

Male	Female	Total
8	12	20

Fatality by Child's Race

Caucasian	African American	Hispanic	Total
6	14	0	20

Fatality by Jurisdiction

Newport News	Norfolk	Hampton	Portsmouth	York-Poquoson	Chesapeake	Virginia Beach	Total
5	5	3	3	2	1	1	20

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Medical Neglect	Total
9	11	4	24

Fatality by Cause of Death (Physical Abuse)

Shaken Baby Syndrome	Internal Injuries	Broken Bones	Immersion Burns/Scalds	Cocaine Toxicity	Total
4	2	1	1	1	9

Fatality by Cause of Death (Neglect)

Drowning	Medical Neglect	Fire Death	Suffocation	Gunshot	Abandoned At Birth	Other	Total
6	1	1	1	1	1	1	12

Fatality by Previous Child Protective Services (CPS) Contact

Previous CPS Contact	No CPS Contact	Total
10	10	20

Fatality by Sex of Perpetrator

Male	Female	Both	Total
6	13	1	21

Fatality by Race of Perpetrator

African-American	Caucasian	Hispanic	Total
15	5	1	21

Fatality by Age of Perpetrator

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Total
4	5	6	3	2	1	21

Fatality by Role of Perpetrator/Caretaker

Mother	Sitter Boyfriend	Sitter Hired	Sitter Girlfriend	Sitter Uncle	Father	Total
12	4	2	1	1	1	21

Criminal Charges Filed

Charges Filed	No Charges Filed	Total
15	6	21

Charges Not Filed

Physical Neglect	Medical Neglect	Physical Abuse	Total
4	1	1	6

Neglect Case by Sex of Perpetrator

Female	Male	Total
12	2	14

Physical Abuse by Sex of Perpetrator

Female	Male	Total
3	6	9

APPENDIX XIX

Eastern Region Child Abuse and Neglect Fatalities: FY 97

There were a total of 10 fatalities.

Fatality by Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
4	1	1	0	4	10

Fatality by Child's Sex

Male	Female	Total
4	6	10

Fatality by Jurisdiction

Newport News	Virginia Beach	Norfolk	Portsmouth	Chesapeake	Suffolk	Total
3	3	1	1	1	1	10

Cause of Death

Gunshot	Asphyxiation	Internal Injuries	Skull Fracture/ Brain Damage	Total
3	2	2	3	10

Fatality by Child's Race

Caucasian	African American	Hispanic	Total
5	3	2	10

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Medical Neglect	Total
10	0	0	10

APPENDIX XX

EASTERN REGION CHILD ABUSE AND NEGLECT FATALITIES: FY 96

There were a total of 9 fatalities.

Fatality by Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
4	1	2	0	2	9

Fatality by Child's Sex

Male	Female	Total
4	5	9

Fatality by Jurisdiction

Chesapeake	Norfolk	Portsmouth	Newport News	Hopewell	Suffolk	Total
2	2	2	1	1	1	9

Cause of Death

Gunshot	Asphyxiation	Internal Injuries	Skull Fracture/ Brain Damage	Total
2	2	2	3	9

Fatality by Child's Race

Caucasian	African American	Hispanic	Total
5	4	0	9

Fatality by Social Service Finding

Physical Abuse	Physical Neglect	Medical Neglect	Total
9	0	0	9

Sex of Victim by Sex of Perpetrator

Female Perpetrator Female Victim	Female Perpetrator Male Victim	Male Perpetrator Female Victim	Male Perpetrator Male Victim	Total
5	9	6	1	21

Prosecutions by Jurisdiction (Total Cases/Cases Prosecuted)

Newport News	Norfolk	Hampton	Portsmouth	York-Poquoson	Chesapeake	Virginia Beach	Total
5/3	5/5	3/2	3/1	2/2	1/1	2/1	21/15

Perpetrator Not Charged by Sex

Female	Male	Total
5	1	6

Perpetrator Not Charged by Race

African-American	Caucasian	Hispanic	Total
5	1	0	6

APPENDIX XXI

CHILD FATALITIES-FOUNDED-EASTERN REGION-FY 1996-2015 (20 years)

There were a total of 265 child fatalities founded as a result of abuse or neglect. *Note: In the deaths of a number of children, there was more than one caretaker founded for abuse or neglect making a total count of abusers different from the number of deceased children. Also some of the statistics below were not compiled during the early years of team reviews, so please note the years for which the statistics apply before making comparisons.*

Fatality by Child's Age

<1yr.	1yr.	2yrs.	3yrs.	4+yrs.	Total
116	47	34	16	52	265

Fatality by Child's Sex

Male	Female	Total
144	121	265

Fatality by Child's Race

Caucasian	African - American	Hispanic/White	Asian	Biracial	Unknown	Total
104	140	5	1	14	1	265

Fatality by Primary Social Service Finding

Physical Abuse	Neglect	Total
160	105	265

Fatality by Jurisdiction

Acco-mack	Chesa-peake	Dinwiddie County	Franklin	Greensville County Emporia	Hampton	Hopewell	Isle of Wight	James City-Wmsbg	Newport News	Norfolk
5	27	2	2	2	23	1	7	6	35	57

Ports-mouth	Prince George	South-ampton	Suffolk	Surry	Sussex	Virginia Beach	York-Poquo-son	Location Unknown	Total
22	4	1	9	2	3	50	6	1	265

Fatality by Cause of Death (Physical Abuse)

Asphyxiation	Burns	Drowning	Gunshot	Inflicted Traumatic Brain Injury	Blunt Force Trauma	Internal Injuries	Stabbing	Poisoning	Other	Total
15	3	7	15	68	12	23	5	3	7	158

Fatality by Cause of Death (Neglect)

Abandon-ment	Dehydra-tion	Inadequate Supervision Asphyxiation Hyperthermia	Inadequate Supervision Dog Bite	Inadequate Supervision Drowning	Inadequate Supervision DUI	Inadequate Supervision Fire	Inadequate Supervision Gunshot	Inadequate Supervision Poisoning	Inadequate Supervision Suffocation or Asphyxiation
6	5	1	1	33	2	6	8	3	12

Inadequate Supervision Suicide	Inadequate Supervision Choking	Inadequate Supervision Car Accident	Inadequate Supervision Overdose	Inadequate Supervision Unsafe Sleep	Medical Neglect	Other	Undetermined	Total
1	1	1	2	1	9	9	6	107

Fatality by Previous Social Services Contact (FY 98-15)

Previous DSS Contact	Screen Outs	Total Cases in Time Period (FY 98-15)
96	2	246

Fatality by Sex of Perpetrator (FY 98-15)

Female	Male	Unknown	Total
154	157	6	317

Fatality by Race of Perpetrator (FY 98-15)

African-American	Caucasian	Biracial	Asian	Hispanic	Native American	Unknown	Total
179	124	1	1	2	1	9	317

Fatality by Age of Perpetrator (FY 99-15)

15-19yrs.	20-24yrs.	25-29yrs.	30-34yrs.	35-39yrs.	40+yrs.	Unknown	Total
22	99	54	33	16	41	16	281

Fatality by Role of Perpetrator/Caretaker (FY 99-15)

Father	Mother	Step-Father	Step-Mother	Other Relative	Paramour	Childcare Provider	Foster Parent	Institution Caretaker	Other Household Member	Unknown	Total
86	96	8	1	24	37	21	7	4	1	11	296

Appendix XXII
Eastern Region Abandoned Babies
1995-2015
(Compiled by the Eastern Region Child Fatality Review Team)

FY 95	FY 96	FY 97	FY 97	FY 98	FY 99	FY 00	FY 01
February 1995	June 1996	December 1996	February 1997	March 1998	September 1998	September 1999	July 2000
African-American	African-American	Unknown	African-American	African-American	Unknown	Caucasian	African-American
Female	Female	Female	Male	Male	Male	Male	Male
Portsmouth	Portsmouth	Virginia Beach	Portsmouth	Norfolk	York-Poquoson	Isle of Wight	Norfolk
Found at SPSA (Southeastern Public Service Authority refuse and recycling plant)	Found at SPSA	Found hanging on a coat hook in a plastic sack at Lillian Vernon distribution center	Found at SPSA	Found in a duffle bag in a wooded area	Found in a trashcan in a campground	Found in a toilet in a home	Found in his mother's backyard
Founded by DSS Perpetrator Unknown	Founded by DSS Perpetrator Unknown	Founded by DSS Perpetrator Unknown	Founded by DSS Perpetrator Unknown	Founded by DSS 18 year old mother; Pled guilty to 2nd degree murder; Was sentenced to 8 years.	Founded by DSS Perpetrator Unknown	Founded by DSS 16 year old mother Did not admit guilt Under an Alford plea	Founded by DSS 20 year old mother Found guilty by jury; recommended 15 years

Appendix XXII (Con't)
Eastern Region Abandoned Babies
1995-2015

FY 02	FY 02	FY 02	FY 03	FY 06	FY 07	FY 11
February 2002	February 2002	March 2002	January 2003	March 2006	Late 2007?	May 2011
African American	Caucasian	Caucasian	Caucasian	African American	Caucasian	Black
Female	Male	Female	Male	Female	Male	Male
Norfolk	Chesapeake	Virginia Beach	Chesapeake	Norfolk	Gloucester	Newport News
Found in a box in a rented storage unit	Found in a bedroom closet wrapped in a trash bag in a trash can in a trailer park	Found in a toilet at First Colonial High School	Found frozen in a wooded area covered by a blanket & face down in the snow	Found in a construction dumpster wrapped in a plastic bag	Found buried in a shed behind the parents' trailer	Found in apartment storage shed hidden in a black trash bag
Founded by DSS 18 year old Norfolk State student arrested and charged. Convicted of 1st degree murder; sentenced to 20 years in prison, with 17 years suspended.	Founded by DSS 25 year old mother identified; Returned to Tennessee On a parole violation for the death of another newborn that Was thrown in a trash bin there in 1996; ME could not determine 100% if child was born alive; Never charged in Chesapeake. Jailed in Tennessee for 4 years for violation of parole.	Not investigated by DSS Mother, a 15 year old high school student, identified. ME could not determine if child was born alive. No charges filed.	Founded by DSS; Perpetrator Unknown.	Perpetrator Unknown	Cause of death undetermined. Both parents were prosecuted.	Cause of death undetermined. Mother was prosecuted.

Appendix XXII (Con't)
Eastern Region Abandoned Babies
1995-2015

FY 14
September 2013
African American
Female
Dinwiddie County
Found in toilet; mother claiming she did not know she was pregnant, gave birth in toilet and left the baby there.
Founded by DSS; mother and grandmother were charged; mother pled guilty to involuntary manslaughter and was sentenced to a 3 year suspended sentence; the grandmother died shortly after the incident and charges against her were dropped.

Appendix XXIII
Child Abuse Deaths in Virginia and the Eastern Region 1982-2015*

Year	Virginia Deaths	Eastern Region Deaths
1982	10	
1983	19	
1984	16	
1985	14	
1986	14	
1987	27	
1988	25	
1989	34	
1990	28	
1991	34	
1992	32	
1993	43	
1994	26	
1995	27	
1996	25	9
1997	29	10
1998	38	20
1999	35	11
2000	37	17
2001	31	10
2002	28	13
2003	31	20
2004	29	13
2005	26	9
2006	39	13
2007	29	9
2008	35	11
2009	34	16
2010	44	16
2011	30	10
2012	38	16
2013	37	16
2014	39	17
2015	52**	13

*Note that some numbers vary from the totals on state reports. Once a state report is "published," the number are not changed if an additional case from that year is discovered or founded. The Eastern Region reports are updated when previous deaths become known.
**As of the date of this report (3/28/16) statewide 6 cases are pending and 3 are being appealed.

Appendix XXIV

Virginia Department of Social Services
Child Fatality Investigations by Region

FY 2011 and FY 2012 and FY 2013 and FY 2014 and 2015 (Incomplete)

(As of 3/28/16, there were 6 pending cases and 3 on administrative appeal.)

REGION	FOUNDED					UNFOUNDED					PEND-ING	UNDER APPEAL	TOTAL INVESTIGATIONS				
	FY 11	FY 12	FY 13	FY 14	FY 15	FY 11	FY 12	FY 13	FY 14	FY 15	FY 15	FY 15	FY 11	FY 12	FY 13	FY 14	FY 15
EASTERN	10	16	16	17	13	30	39	31	30	33	0		40	56	47	47	46
CENTRAL	4	4	5	5		6	5	15	11		2		10	9	20	16	
NORTHERN	4	5	5	10		4	12	12	15		2		10	18	19	27	
PIEDMONT	7	3	6	8		8	11	5	15		2		16	14	12	24	
WESTERN	6	9	5	7		3	3	3	2		0		10	13	8	10	
STATE TOTALS	31	37	37	47	52			47		52	6	3	86	110	106	124	131